Texas Department of Aging
and Disability Services

Form 2705
June 2014

Certification of Need for Major Medical Treatment

To be signed by a physician

Please type or print clearly

Facility Name	Vendor Number
Individual's Name	Social Security Number

Department Use

_____
Case Number
(to be assigned by SDM)

Physician's Name	Specialty	Office Area Code and Phone Number
Office Address (Street, City, State, ZIP)		Fax Area Code and Phone Number

Date of Examination: _____

As a result of such examination, I diagnosed the following medical condition(s):

My diagnosis is based on the following diagnostic tests/examinations: **(Please list tests, dates and results.)**

The following major medical treatment/procedure is proposed:

I am the physician who will perform the proposed major medical treatment/procedure: ☐ Yes ☐ No

Risks and Benefits: You may attach prepared documents that state the risks and benefits of the proposed major medical treatment/procedure specified, however, all questions must be addressed on this Certification of Need form.

In my clinical opinion:

The risks of the proposed major medical treatment/procedure are indicated: ☐ Below ☐ Attached

The need for and benefits of the proposed major medical treatment/procedure are indicated: ☐ Below ☐ Attached

Are there other risk factors for this individual that could significantly increase the probability of illness, injury or death secondary to this major medical treatment/procedure?

☐ Yes ☐ No

If yes, please list:

Department Use

Case Number
(to be assigned by SDM)

Alternatives:

Are there alternative treatments/procedures available to this individual? ☐ Yes ☐ No

If yes, answer questions (a) through (e):

a. The alternative treatments/procedures are indicated: ☐ Below ☐ Attached

b. The risks of the alternatives listed are indicated: ☐ Below ☐ Attached

c. The benefits of the alternatives listed are indicated: ☐ Below ☐ Attached

d. The alternatives were: ☐ Attempted, but unsuccessful ☐ Not attempted and rejected

Explanation:

e. The proposed treatment/procedure is preferred to the alternatives because:

The risks of non-treatment are indicated: ☐ Below ☐ Attached

At this time, I recommend the procedure be done under: ☐ IV sedation ☐ General anesthesia

a. The risks of IV sedation for this individual are indicated: ☐ Below ☐ Attached

b. The risks of general anesthesia for this individual are indicated: ☐ Below ☐ Attached

Send any blank consents that are required by the dentist, anesthesiologist, clinic or hospital.

In your opinion, does the individual understand the proposed major medical treatment/procedure risks, benefits and alternatives?

☐ Yes ☐ No

The individual's expressed opinion about the proposed major medical treatment/procedure, if any, is:

Department Use
_____ Case Number (to be assigned by SDM)

The above information and statements are, to the best of my knowledge, truthful and complete.

Printed Name – Physician	Signature – Physician	Date

If someone other than the physician completed this Certification of Need form, provide the following information about that person:

Printed Name	Signature	Date

Title	Employer's Name

Send completed form to:
Surrogate Decision Making Program
Texas Department of Aging and Disability Services
Consumer Rights and Services
701 West 51st St.
Mail Code E-249
Austin, TX 78751

If you have questions or need assistance:
Call: 512-438-4275 / 512-438-4193 / 512-438-4573
Fax: 512-438-2883